PROSPECTS FOR THE FUTURE*

BERTRAND M. BELL, M.D.
Professor of Medicine
Albert Einstein College of Medicine
Bronx, New York

WHILE THE ISSUE OF CHRONIC SLEEP DEPRIVATION as a built-in feature of house staff training and its potential deleterious effects on patients has elicited the greatest interest, this focus, although important and a major issue addressed by the Bell committee, will not be of major importance for the future. I can say this with a great deal of confidence because the evidence is already in that the middle class public—who first became really aware of sleep deprivation and its potential deleterious effects on patient care—will no longer accept it. Nor will the residents who have been chronically sleep deprived!

The *AMA News* of October 18, 1990, reported that the California Association of Interns and Residents joined the 925,000 Service Employees International Union so that they could use the clout of the labor movement to reduce their hours and improve their working conditions. The California story is one of many movements afoot to rationalize the working conditions of house staff in our country. However, not surprisingly, if it is true that when an idea whose time has come the idea will appear in more than one place, then this can be clearly illustrated by the October 13, 1990 *British Medical Journal* article "Junior Hours: International Overview" that detailed the situation in six countries where various systems are under consideration to eliminate chronic sleep deprivation as a feature of graduate medical education. Rationalizing the hours and working conditions of house staff is now clearly a worldwide issue.

Perhaps of greatest importance indicating that rationalizing the working conditions of house staff and their supervision is an idea whose time has come, is the fact that the American Board of Internal Medicine has incorporated into their requirements an 80-hour week and specifications, which

*Presented as part of a *Conference on Regulation of Residency Training: An Appraisal of Recent Changes* held by the Associated Medical Schools of New York, the Committee on Medical Education of The New York Academy of Medicine, and the United Hospital Fund of New York November 28, 1990.

Address for reprint requests: Ambulatory Care Service—1N17—Jacobi, Bronx Municipal Hospital Center, Pelham Parkway and Eastchester Road, Bronx, NY 10461

recognize that house staff training is primarily an educational experience. This should remind the American Board of Medical Specialties that even if they are against the ACGME support of specific hour restrictions, it is infinitely better for the profession to define the hours and the working conditions of house staff than it is for government to make those definitions. The drive on the part of various antediluvian elements such as the ABMS must be derailed because they do not recognize that if we don't do the right thing we will be further regulated by the government. What hopefully will happen is that the private voluntary agencies, such as the various boards, will promulgate regulations that will satisfy the public and thereby eliminate the need for governmental regulations and legislation. Considering the alacrity with which government is ready to regulate the profession, it is sad to note that surgical program directors in New York State are not complying with *their* modifications of the 405 regulations. The modifications were obtained with assurances that surgical programs would comply with the intent of the regulations. Instead, the modifications have become a subterfuge for not adhering to the regulations. Surgical residents, particularly early in their training, are still working in excess of 100 hours per week. They continue to be sleep deprived and chronically fatigued and can hardly be expected to have either a quality educational experience or to be capable of being safely involved in patient care.

The modifications of the code for surgical programs could be considered an experiment that gives the surgeons an opportunity to demonstrate that they can regulate themselves. That they give every indication that they are not attempting to fulfill either the letter or the intent of the modified regulations is disheartening and indicates that we probably cannot regulate ourselves. If the surgeons mean to adhere to the regulations then systems should be in place to document that surgical residents when on call are "generally resting" and that in a clearly meaningful fashion suffer "infrequent interruptions" and that those interruptions "are limited to patients for whom the resident has continuing responsibility." There also should be documentation of "policy and procedures." I hope that surgical program directors will begin to observe the spirit and intent of the regulations.

Ignoring for now the potential issues involving the surgeons, if the hours and the working conditions of house staff are not the real issue for the future, what is the real issue? The real issue and the one we have heard very little about concerns supervision. It was quite apparent to the committee that there was and still is, in spite of the regulations, a serious problem with supervision. The intent of the supervisory recommendations was an attempt to cor-

rect the public viewpoint that holds that the profession had not protected their interests by permitting residents to assume responsibility for the care of patients in hospitals without adequate supervision. I believe that this premise that residents currently assume responsibility for the care of patients in teaching hospitals without adequate supervision is fundamentally correct.

Please remember that the grand jury report, instead of indicting physicians, indicted the graduate medical education system. The grand jury report never said that the death of Libby Zion was in any way related to sleep deprivation or the working conditions of house staff per se. The report did emphasize lack of supervision by attending physicians of very junior house staff. Libby Zion's attending doctor never saw her on that Sunday evening.

The tendency in graduate medical education programs to allow house officers to function without the supervision of seasoned attendings is an issue much more important than the hours issue. In medicine, and even in surgery, supervision of house staff by attending physicians is not made as clear as it must be. The attending physician has the responsibility for the care of each and every patient to whom he is assigned. *Patients do not pay house staff to take care of them in the hospital, they pay attending physicians.* There is a phenomenon which can be referred to as the house staff subculture, whereby residents feel they are responsible for patient care and in many ways consider the attending staff superfluous. Studies in New York City by the Greater New York Hospital Association demonstrate that on weekends and nights the senior ranking physician in many teaching hospitals is a second year resident in medicine, Ob/Gyn, and pediatrics, and only a fourth year resident in surgery. The presence of senior attendings or even senior residents who are on call and come in to see their patients is hard to document. We could not find any hospitals that keep a roster of the number of times senior attendings are called and actually come in to see their patients or in situations where physicians are in house, how often they are called and actually see the patient.

The concept of graduated responsibility has been a smoke screen to obscure the fact that medical education, which is hierarchical and authoritarian, encourages (although this need not be the case) physicians to hide what they do not know. One purpose of the supervisory provisions was to change the ambience of medical education. Rather than continue to foster a system that encourages residents to hide their ignorance; never to admit to a senior person that they don't know; to act and bluff rather than ask, it was hoped that the supervisory provisions would make available collegial, friendly, nonpunitive attendings and senior residents instantly, graciously, and willingly available so that the house staff will begin to feel comfortable asking for help. An

admission of "I don't know, please help" will then become a very acceptable approach to the care of many patients. House staff and even attendings will not try to bluff or to stumble their way through uncertain and difficult situations. Instead, they will comfortably call for needed help. It is important that the various teaching services develop mechanisms that can demonstrate that attendings and senior residents are being called, what they are being called for, and whether the call was answered.

The whole issue of the control of supervision may unfortunately have already been removed from our hands. A new and onerous bureaucracy set up by HCFA, the PRO, could, unless we take vigorous action, be responsible for thoroughly revamping supervision and thereby the education of house officers. This system will change the attitude of attending physicians. Attendings will not be able to use a second year resident's opinion as a basis of deciding whether they need to see the patient whom they sent to the emergency room during off hours. Perhaps the PRO will help medical policy makers to recognize and to act on the current imbalance between hospital medicine as service and hospital medicine as graduate medical education.

The committee also made a very important point that so far has mostly been ignored by program directors: "In order to implement these recommendations without an increase in the number of residents, various changes will have to be introduced. Among these will be a redistribution of the patient contact hours in the progressive years of the residency.... It is likely that a system change will be necessary." I believe that the 405 regulations will encourage radical changes in the format of residency programs not only to meet the regulations but to adjust to the changed nature of hospital practice as it relates to medical education.

Finally, I would like to comment on another part of the new regulations that has not received much publicity but definitely needs a place in the limelight. This concerns attempts to address the issue of ancillary help for which some hospitals received, quite unexpectedly, considerable sums of money. At a recent meeting of our department of medicine, it was pointed out that at our hospital we have phlebotomy teams, IV teams, and messengers and transporters around the clock and this has led to a happy educational problem. The new problem is how to teach the house staff to use this long-needed group of caregivers. I hope other hospitals now have this problem and have done as well in making this ancillary help available to our patients and the house staff.